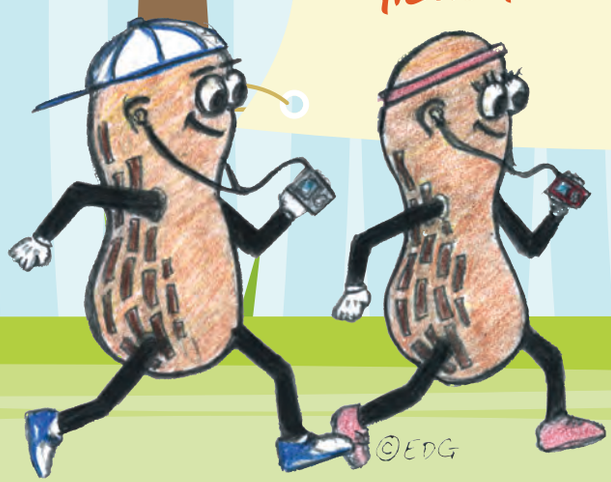
STATE HEALTH BENEFIT PLAN

Active Employee Decision Guide 2009



Steps to Maintain Good Health:

- Select the Best Health Care Option
- Seek Preventative Care
- Complete Your Health Assessment
- Participate in Health Coaching
- Take Charge of Your Health

OPEN ENROLLMENT
October 10–November 10, 2008

Georgia Department of Community Health

Phone Numbers/Contact Information

State Health Benefit Plan (SHBP): www.dch.georgia.gov/shbp_plans

Vendor	Member Services	Pharmacy	Web Site
UnitedHealthcare			
Definity HRA	800-396-6515		www.myuhc.com/groups/gdch
PPO	877-246-4189 TDD 800-955-8770	800-372-5802	www.myuhc.com/groups/gdch
Choice HMO	866-527-9599 TDD 800-955-8770		www.myuhc.com/groups/gdch
HDHP	877-246-4195 TDD 800-842-5754	800-372-5802	www.myuhc.com/groups/gdch
CIGNA Healthcare			
HRA, PPO, HMO, HDHP	800-633-8519 TDD 800-576-1314	800-633-8519	www.cigna.com/shbp
Kaiser Permanente	800-611-1811 800-255-0056		www.kaiserpermanente.org
Pharmacy		Contact your respective vendor	www.dch.georgia.gov/shbp_plans
All Options: Eligibility	404-656-6322 800-610-1863		www.dch.georgia.gov/shbp_plans

Disclaimer: This material is for informational purposes and is not a contract. It is intended only to highlight principal benefits of the medical plans. Every effort has been made to be as accurate as possible; however, should there be a difference between this information and the Plan documents, the Plan documents govern. It is the responsibility of each member, active or retired, to read all Plan materials provided in order to fully understand the provisions of the option chosen. Availability of SHBP options may change based on changes in federal or state law.

Page 2 of this guide contains Plan changes effective January 1, 2009. Prior to the start of the 2009 Plan Year, or shortly thereafter, the Plan will post a new Summary Plan Description (SPD) for each Plan option to the DCH Web site, www.dch.georgia.gov/shbp_plans. This SPD is your official notification of Plan changes effective January 1, 2009. You may print or request a paper copy by calling the Customer Service number on the back of your ID card. Please keep your Summary Plan Description (SPD) for future reference. If you are disabled and need this information in an alternative format, call the TDD Relay Service at (800) 255-0056 (text telephone) or (800) 255-0135 (voice) or write the SHBP at P.O. Box 38342, Atlanta, GA 30334.

Georgia Department of
Community Health

Rhonda M. Medows, MD, Commissioner *Sonny Perdue, Governor*

2 Peachtree Street, NW
Atlanta, GA 30303-3159
www.dch.georgia.gov

October 1, 2008

Dear State Health Benefit Plan (SHBP) Member:

Welcome to the 2009 Open Enrollment. This year Open Enrollment will be held October 10 – November 10, 2008. Employees will again make their health election on the Web at www.oe2009.ga.gov.

SHBP is committed to providing a comprehensive benefit program with multiple choices while keeping prices affordable for all members. We have also heard your feedback and ideas for improving your benefit program and we are happy to announce some exciting changes that will be offered January 1, 2009:

- To streamline administrative costs and improve network access, SHBP conducted a competitive procurement earlier this year and awarded statewide contracts to **CIGNA Healthcare** and **UnitedHealthcare** (effective January 1, 2009). These two vendors offer the broadest access to providers across the state and proven quality care. Each vendor will offer a Health Reimbursement Arrangement (HRA), High Deductible Health Plan (HDHP), Preferred Provider Organization (PPO), and Health Maintenance Organization (HMO) option to all employees, retirees and their dependents. Eligible retirees will also have the choice of a Medicare Advantage Private Fee for Service with Prescription Drugs option from both vendors.

- SHBP has responded to members' requests about premium tiers by changing the pricing tiers for your monthly insurance premiums. The number of coverage tiers will increase from two tiers to four tiers this Plan Year. The new tiers are:

  Employee

  Employee + Child(ren)

  Employee + Spouse

  Employee + Spouse + Child(ren)

- For the HRA option, members will see new incentives for wellness/preventative care by completing health assessments and obtaining an annual physical.

- Mental health benefits have also been expanded to more closely match those of the medical benefits with unlimited days for inpatient and outpatient treatment.

The Georgia Department of Community Health, which administers SHBP, is committed to providing you with meaningful choices in your options, while keeping costs down. Be assured that we will continue to seek to provide you with these options, low premiums and tools to help you make the best decisions for you and your family members.

Sincerely,

Rhonda M. Medows, M.D.
Commissioner

Contents

Welcome to Open Enrollment for the State Health Benefit Plan for Coverage Effective January 1, 2009 – December 31, 2009

The Open Enrollment dates are October 10 through November 10, 2008. This guide will provide you with a brief explanation of each Plan option, important changes in your SHBP options, steps on how to make your Open Enrollment election, information about the health and wellness features available through the health plan options and a comparison of benefits chart. This guide, the *Active Employee Decision Guide,* can also be found at www.dch.georgia.gov/shbp_plans or www.oe2009.ga.gov.

Employees will make their health election at www.oe2009.ga.gov and the Web site will be open beginning 12:01 a.m. on October 10 and will close at 4:30 p.m. on November 10, 2008.

What's Changing for 2009?

New Offerings

Through a comprehensive and competitive procurement process, CIGNA Healthcare and UnitedHealthcare were chosen to provide your medical and pharmacy benefit plans effective January 1, 2009. Strong statewide and national access to physicians and hospitals as well as documented clinical excellence were the two most critical factors in the award. CIGNA Healthcare and UnitedHealthcare also both demonstrate expertise and innovation in wellness and consumerism, two important areas of focus for SHBP.

New Plan Option Offerings

CIGNA Healthcare and UnitedHealthcare will each offer the following options:

- Health Reimbursement Arrangement (HRA)
- High Deductible Health Plan (HDHP)
- Preferred Provider Organization (PPO)
- Health Maintenance Organization (HMO)
- Medicare Advantage Private Fee for Service Plan (MA PFFS) (retirees age 65 and older)

No Longer Offered

- The Indemnity Option
- The BlueCross BlueShield of Ga BlueChoice HMO and Lumenos plan options
- The Consumer Choice Option (CCO)
- The Kaiser Permanente Option will be frozen and will be offered **only** to individuals currently enrolled in this option

Change in Premium Structure from Two to Four Tiers

- EE = Employee
- ES = Employee + Spouse
- EC = Employee + Child(ren)
- EF = Employee + Child(ren) + Spouse
- During Open Enrollment, elect the coverage tier you desire for the dependents that you choose to cover
- You will be locked into the tier for the entire plan year unless you experience a qualifying event
- If a tier election is not made during open enrollment, you and any covered eligible dependents, as of December 1, 2008, will be placed into the appropriate coverage tier. You will be locked into that coverage tier for 2009 unless you experience a qualifying event
- The tier changes provide a more equitable distribution of actual claim costs. For example, an employee who covers his/her spouse and children generally has higher claim costs than an employee who just covers his/her children

Premiums

- Overall cost increase on average to employees: 7.5 percent
- The HRA and HDHP options will receive a lower rate increase (3 to 6 percent depending on the tier); non-Consumer Driven Health Plans will receive a larger increase (2 to 10 percent depending on the tier)
- Re-alignment of rates from two to four tiers caused some large swings in rates for the family-tier. A 10 percent cap was put on all rate increases
- Some tiers will have higher increases in 2009 than others, as the rates are realigned properly with the expected claim costs

Eligibility Changes

Disabled Dependents

- You may apply during open enrollment, to enroll an over-age disabled child not covered under SHBP prior to age 19 but who was disabled prior to age 26
- Call SHBP at (800) 610-1863 to request the disabled dependent forms. You will add the child as a dependent during Open Enrollment but coverage will be withheld until approved. These forms along with the indicated medical documentation of your child's disability must be received and approved by SHBP prior to coverage being granted

Dependent Verification

- For 2009, members elect their coverage tier during Open Enrollment and are locked-in to that tier for the entire year unless a qualifying event occurs
- The dependent's coverage will remain inactive until the appropriate documentation has been received and verified by SHBP
- SHBP will allow members to submit verification of their dependent's eligibility **any time** during the current plan year
- The tier is locked-in regardless of whether dependent verification is submitted or not to the SHBP

SHBP Acronyms

CDHP – Consumer Driven Health Plan

DCH – Georgia Department of Community Health

FSA – Flexible Spending Account

HDHP – High Deductible Health Plan

HMO – Health Maintenance Organization

HRA – Health Reimbursement Arrangement

HSA – Health Savings Account

PPO – Preferred Provider Organization

SHBP – State Health Benefit Plan

SPD – Summary Plan Description

UHC – UnitedHealthcare

EE – Employee

ES – Employee + Spouse

EC – employee + Child(ren)

EF – Employee + Child(ren) + Spouse

Surviving Spouse Coverage

- If a surviving spouse becomes eligible for coverage as an active employee, he/she must be covered under SHBP as an active employee through his/her employer and NOT as a surviving spouse
- When surviving spouse leaves active employment, **he/she must notify SHBP within 31 days** to regain coverage as a surviving spouse

Spousal Surcharges

SHBP may audit the elections of employees who are covering their spouses and their answers to the spousal surcharge in 2009. An amnesty period will be given for employees to make any corrections during the Open Enrollment period for coverage January 1, 2009. Additional information will be provided at a future date about the audit process.

Enhancements and Changes

Enhanced Mental Health and Substance Abuse Benefits

Day limitations no longer apply to the following:

- Inpatient Facility
- Inpatient Professional Charges
- Outpatient Visits
- Partial Day Hospitalization/Intensive Outpatient

NOTE: Number of days and/or visits authorized remain subject to health plan approval

HRA and HDHP Enhancements

- Employee and Spouse can each earn an additional $125 by taking an annual physical and completing a health assessment (HRA only)
- No cost for certain asthma, diabetes and cardiac prescriptions for members enrolled and compliant with the disease state management program (HRA only)
- Treatment of Morbid Obesity at approved Centers of Excellence for members who meet the medical guidelines and complete specified requirements (available on HDHP also)
- Allowance for hearing aids $1500 every 5 years (available on HDHP also)
- HRA credits and deductibles will be adjusted to reflect the new tiers as follows:

HRA Deductible and Out-of-Pocket Limit – January 1, 2009						
Tier	2008 HRA Credits	2009 HRA Credits	2008 Deductibles	2009 Deductibles	2008 Maximum In & Out-of-Network Out-of-Pocket Limit	2009 Maximum In & Out-of-Network Out-of-Pocket Limit*
EE	$500	$500	$1,000	$1,000	$2,000	$2,000
ES	–	$1,000	–	$1,750	–	$3,250
EC	–	$1,000	–	$1,750	–	$3,250
EF	$1,000	$1,500	$2,000	$2,500	$4,000	$4,500

**These deductibles will be reduced by the HRA dollar credits.*

HDHP Deductibles – January 1, 2009				
Tier	2008 Deductibles	2009 Deductibles	2008 Out-of-Network Deductibles	2009 Out-of-Network Deductibles
EE	$1,100	$1,150	$2,200	$2,300
ES	–	$2,300	–	$4,600
EC	–	$2,300	–	$4,600
EF	$2,200	$2,300	$4,400	$4,600

PPO Changes

SHBP PPO Out-of-Pocket Limit – January 1, 2009				
Tier	2008 Out-of-Pocket Maximum	2009 Out-of-Pocket Maximum	2008 Out-of-Network Out-of-Pocket Maximum	2009 Out-of-Network Out-of-Pocket Maximum
EE	$1,100	$1,500	$2,200	$3,000
ES	–	$2,250	–	$4,500
EC	–	$2,250	–	$4,500
EF	$2,200	$3,000	$4,400	$6,000

HMO Changes

- The deductible and maximum out-of-pocket limits are changing
- HMO Office co-pays are increasing to $30 for primary care and specialists
- HMO co-pays are increasing for preferred prescription drugs from $25 to $30 and non-preferred prescription drugs from $50 to $75

HMO Deductibles and Out-of-Pocket Limits – January 1, 2009				
Tier	2008 Deductibles	2009 Deductibles	2008 Out-of-Pocket Maximum	2009 Out-of-Pocket Maximum
EE	$200	$400	$1,000	$1,500
ES	–	$600	–	$2,250
EC	–	$600	–	$2,250
EF	$400	$800	$2,000	$3,000

Transition of Care

Transition of Care for BlueCross BlueShield of Ga BlueChoice HMO and Lumenos Members and UnitedHealthcare Indemnity and CCO Members

- Transition of care will be provided for if treatment is needed after the end of December. To request transition of care, call the Customer Service number shown on your new ID card by December 31, 2008
- If you have any medical or pharmacy claims for services on or before December 31, 2008, these claims must be received by BlueChoice, Lumenos or UnitedHealthcare no later than March 31, 2009. This requirement also applies to any requests for appeals and adjustments. All claims and requests for appeals and adjustments received after March 31, 2009 will be denied. Please contact your 2008 healthcare vendor to obtain the address.

Open Enrollment

Who Must Participate in Open Enrollment?

EVERYONE who wants to:

- Continue current health coverage and not pay surcharges
- Change tiers
- Add or disenroll eligible dependents
- Change health coverage options
- Discontinue coverage
- Enroll for health coverage

Additionally, **BlueCross BlueShield of Ga Blue Choice HMO**, **Lumenos**, **Indemnity** and **Consumer Choice Option members** must make an election for a new option.

What Should I Do Before I Go Online for Open Enrollment?

- Evaluate your health care needs
- Read this *Decision Guide* completely for important information about Plan changes
- Review the letter from Thomson Reuters that compares your 2007 medical and prescription costs against your 2009 benefit design and premiums to assist you in selecting the most cost effective plan choice for you
- If you didn't receive the letter, verify your address is correct when making your health decision and correct if wrong
- Check to see if your option will be offered in 2009
- Use the Plan Cost Estimator for CIGNA Healthcare at www.cigna.com/shbp and for UnitedHealthcare at www.myuhc.com/groups/gdch
- Check premium rates with your employer or at www.dch.georgia.gov/shbp_plans to help you decide between options
- Call each Plan option or go to the vendor Web site to see which option your physician or provider participates in

- Check the distance you will have to drive to see your provider(s)
- Check Preferred Drug List – co-pays or co-insurance amount
- Check browser requirements – you will need Internet Explorer 5.5 or higher

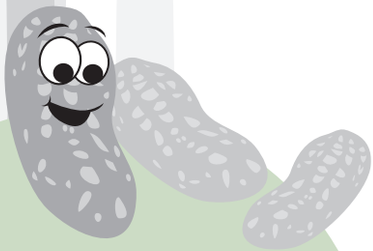
Go online at www.oe2009.ga.gov October 10 – November 10, 2008 to complete Open Enrollment. It's fast, easy, and secure! If you do not have access, please go to your human resources department for assistance.

Follow These Steps to Make Your Online Open Enrollment (OE) Election

1) Go to www.oe2009.ga.gov.
   a) Register the first time you logon, by clicking on "Register."
   b) Enter your policy number (Social Security Number) and date of birth.
   c) Create, enter and re-enter the password to confirm (please remember this password for future reference).
   d) Select a security question and answer it.
   e) Complete by clicking "Register."
   f) You are now logged in. If you exit the system, you will be directed to the "login" screen to enter your policy number and the password you chose above.
2. After reading the "Terms, Conditions and Instructions" text, scroll to the end of the text, click on the "I Agree" button.
3. Your name and address will display. If needed, make any changes. Place a 'check' in the check box to confirm that you have validated your address.
4. Select one of the tiers based on the dependents you wish to cover in 2009.
5. If employee only tier is chosen, you will proceed to the tobacco surcharge question. If you choose one of the other tiers to cover a spouse and/or dependent, the dependents screen will appear. Indicate 'Yes' or 'No' for each dependent to be covered. If you wish to add a new dependent, click on "Add Dependent," input the new dependent information, and click the "Add Dependent" button. Your new dependent should appear.
6. Answer the surcharge questions.
7. Select your health benefit coverage option.
8. A considerations page will be displayed. Please read this page carefully as it is designed to assist you with items you may wish to consider before confirming your election. If you wish to change your election after reviewing this page, click on the "Return" button to go back to the Coverage Selection page. If you are satisfied with your election, click on the "Confirm" button.
9. A Pre-Confirmation page will be displayed. Review your health benefit election, listed dependents and answers to the surcharge questions. If your election is not correct, make any corrections through the edit function. Click 'Confirm' to finalize your election.

having a baby? adopting a child? getting married or divorced?

Remember you only have 31 days from the qualifying event to add or delete dependents. Don't miss the deadline waiting for documentation.



health tip:

Regular exercise can help direct your attention away from daily stress and may contribute to a feeling of mental wellbeing.

10. This is your confirmation page, which reflects your 2009 benefit election. Click 'Printer Friendly' to produce an easy to print version of your confirmation page, which will include a confirmation number. You may also save your confirmation on your computer or to a disk by saving the printer friendly confirmation as a pdf file. This confirmation page is your record of your election. Each time you login to the system and confirm your choices, you will receive a unique confirmation number which you should print or save. The benefits elected and confirmed as of 4:30 p.m. on November 10, 2008 will be your benefit election for the 2009 Plan Year. *NOTE: If a confirmation number does not show, you have not completed the process. You must click "Confirm" to complete your election. If you are unable to print or save this page, copy the confirmation number and keep it in a safe place.*

11. Click on "Logout" to exit.

12. **Do not wait until the last minute** to go online to make your election for 2009 as Web traffic may be heavy and exceptions will not be allowed if you were unable to complete your 2009 election. *REMINDER: the Web site will close at 4:30 p.m. EST on November 10, 2008.*

If you are unable to access www.oe2009.ga.gov to make your OE election, contact your personnel/payroll office for assistance prior to the close of OE.

SHBP Surcharges

You should read and understand SHBP's surcharge policy prior to making your health election for 2009.

Spousal

A $30 per month spousal surcharge will be added to your monthly premium if you elect to cover your spouse and your spouse is eligible for coverage through his/her employment, but chooses not to elect that coverage. If your spouse is eligible for coverage with SHBP through his/her employment, the spousal surcharge will be waived. You will automatically be charged the surcharge if you fail to go online and answer all questions concerning the surcharge. The surcharge will apply to your premium for the 2009 Plan Year.

Please note that SHBP may audit any member covering a spouse who does not pay the spousal surcharge.

Tobacco

A $40 per month tobacco surcharge will be added to your monthly premium if you or any of your covered dependents have used tobacco products in the previous 12 months or if you fail to go online and answer these questions. The surcharge will apply to your premium for the 2009 Plan Year.

The tobacco surcharge may be removed by completing the tobacco cessation requirements. Details are available at www.dch.georgia.gov/shbp_plans. *NOTE: No refunds in surcharges can be given.*

Intentional misrepresentation in response to surcharge questions will have significant consequences. You will automatically lose State Health Benefit Plan coverage for 12 months beginning on the date that your false response is discovered.

What Happens if I Don't Go Online During Open Enrollment?

- If you are enrolled in BlueCross BlueShield of Georgia BlueChoice HMO, Lumenos or UHC Indemnity options, and fail to go online to make a new health election, you will automatically be enrolled in the UHC HRA Option effective January 1, 2009, and you will be assessed the tobacco surcharge and the spousal surcharge (if you cover your spouse)
- If you are enrolled in the Kaiser or UHC Consumer Choice Options (CCO), your coverage will roll over without the Consumer Choice Option, and you will be assessed the tobacco surcharge and the spousal surcharge (if you cover your spouse)
- If you are enrolled in a Kaiser or UHC option, your coverage will roll over and you will be assessed the tobacco surcharge and the spousal surcharge (if you cover your spouse)

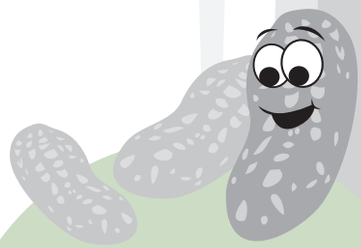
State Personnel Administration (SPA) Flexible Benefits Program Participants [formerly Georgia Merit System (i.e. dental, life, etc.)]

- You will need to go to www.oe2009.ga.gov to make your health benefit election. You should print your confirmation page and make sure it contains a confirmation number. This number confirms your health benefit election for 2009
- If you are eligible for SPA flexible benefits (i.e. dental, life, etc.), you will need to go to a separate Web site, www.team.georgia.gov/flex. You should confirm your flexible benefits elections and print your confirmation statement that includes the confirmation number for your elections

Your 2009 elections must be made on two separate Web sites and you must confirm on both. You should print your confirmations (health and flex) and make sure they both contain confirmation numbers.

Board of Education or Agencies Not Participating in the SPA Flexible Benefits Program (formerly the Georgia Merit System)

You will need to make your health election on www.oe2009.ga.gov, print your confirmation and make sure it contains a confirmation number. This number confirms your health benefit election for 2009. Contact your personnel/payroll office to obtain information regarding your flexible benefits.



health tip:

Eating a low-fat, low-sugar diet with plenty of fruits and vegetables can boost your physical and mental health.

Health & Wellness

Did You Know?

- Georgia ranks 14th in the U.S. for adult obesity
- Georgia has the 13th highest inactivity rate at 25.9%
- Approximately 10% (6,700) of Georgians die from obesity each year
- Georgia is in the top 15 states for the highest obesity rates for youths ages 10 through 17
- Approximately 10% of adult Georgians have diabetes
- Top three causes of death in Georgia – cardiovascular disease, cancer and stroke

shbp tip:

Be on the watch for prize drawings in 2009 for getting your annual physical and completing your health assessment.

What Can You Do About Your Health?

Take a Personal Health Assessment to assist you in learning about potential health risks related to your lifestyle and family history. Each vendor has a health assessment questionnaire available on their Web site that you can complete. After completing the health assessment you will get a customized report that identifies health risks and provides recommendations on ways to help you reduce health risks and suggestions on how to make better lifestyle choices. Personal behaviors that can negatively affect your health can be modified or changed to prevent or reduce the risk of getting certain health conditions/diseases. Members who complete the health assessment may be contacted by the vendor regarding steps you can take to control or eliminate these risks or advise you of tests you may want to consider. You will also be educated on other health coaching services available. Participant data is completely confidential and individual results are not shared with your employer or SHBP. Combined results of all the assessments are used to support and enhance employee health and wellness programs.

Utilize the Preventive Health and Wellness Services One of the best ways to stay healthy is to take advantage of preventive healthcare. Each vendor offers preventive care services. Preventive care is typically defined as periodic health evaluations, such as annual physicals and well-child care, child and adult immunization and screening services, and are subject to guidelines; check with the vendor regarding the plan option you choose to confirm which preventive services are covered. Preventive care generally does not include services intended to treat an existing illness, injury or condition or for diagnostic purposes. Each vendor offers health coaching and wellness programs such as weight loss, nutrition and stress management. Contact the vendors to learn more about the programs they offer. You may also use your local health department to receive benefit coverage for eligible immunizations/vaccinations.

Engage in the Health Management Services Each vendor offers assistance with health care services such as disease management, case management and behavioral health. Please refer to your health plan options for additional details on programs offered.

Call the Nurse Advice Line Each vendor has a 24-hour, seven days a week (including holidays) nurse advice line that is available to assist you in making informed decisions about your health. You can call for professional medical advice regarding medical situations. Check with your health plan option for the telephone number.

Good health is priceless. When you live a healthy lifestyle, you can feel better, live easier and save money on health care expenses!

Understanding Your Plan Options

To maximize your health benefits, it is more important to understand how each SHBP option works. This brief overview will help you determine which option best fits your health care needs. **Keep in mind that this year, you will have two choices for each option listed below. You must select either an option offered by CIGNA Healthcare or UnitedHealthcare.**

Consumer Driven Health Plan Options

The Health Reimbursement Arrangement (HRA) and the High Deductible Health Plan (HDHP) are consumer driven health plan options. These options are structured to provide lower out-of-pocket expenses for many participants and are explained below. Participation in these options impacts your eligibility and the amount you can contribute to a Flexible Spending Account. Additional information to assist you with understanding the rules and differences can be found on page 24 of this *Decision Guide*.

Health Reimbursement Arrangement (HRA)

The HRA is a consumer driven health care option whose plan design offers you a different approach for managing your health care needs. It is similar to that of the PPO with an in-network and out-of-network benefit, except SHBP funds dollar credits to your HRA each year to provide first dollar coverage for eligible health care and pharmacy expenses. The amount in your HRA is used to reduce the deductible and maximum out-of-pocket. After satisfying your deductible, you will pay your coinsurance amount until you reach your out-of-pocket maximum.

Considerations:

- The plan offers unlimited wellness benefits based on age and gender national guidelines when seeing in-network providers only
- There is not a separate deductible and co-insurance for out-of-network expenses
- Unused dollars in your HRA account roll over to the next Plan Year if you are still participating in this option
- HRA dollar credits are part of this option only and can only be used with the HRA option
- Unused dollars in the HRA account will be forfeited if you change options during the Open Enrollment, a qualifying event occurs, or you terminate employment; even if you re-enroll in a subsequent Plan Year
- If you enroll during the year, your HRA dollar credits will be pro-rated based on the number of months remaining in the Plan Year (which is calendar)
- If you experience a qualifying event and change tiers, your new HRA dollar credits only will be pro-rated based on the number of months remaining in the Plan Year; the deductible and out-of-pocket maximum are not adjusted
- If you experience a qualifying event and change tiers from family to single coverage, your HRA dollars will not be reduced
- Certain drug costs are waived if you participate in one of the Disease State Management Programs (DSM) for Diabetes, Asthma and Coronary Artery Disease

shbp tip:

To save money, try over-the-counter brands.

An HRA member with itchy eyes received a doctor's prescription for drops that cost $82. Her pharmacist helped find $12 over-the-counter eye drops that did the same thing. ***Savings to her HRA – $82.***

(over the counter medications are not covered under an HRA.)

High Deductible Health Plan (HDHP) with a Health Savings Account (HSA)

The High Deductible Health Plan (HDHP) design is very similar to that of the PPO with an in-network and out-of-network benefit.

In return for a low monthly premium, you must satisfy a high deductible that applies to all health care expenses except preventive care. **If you have family coverage, you must meet the ENTIRE family deductible before benefits are payable for any family member. You pay co-insurance after you have satisfied the deductible rather than set dollar co-payments for medical expenses and prescription drugs.** Also, you may qualify to start a Health Savings Account (HSA) to set aside tax-free dollars to pay for eligible health care expenses now or in the future. HSAs typically earn interest and may even offer investment options. See the benefits comparison chart that starts on page 16 to compare benefits under the HDHP to other Plan options.

Considerations:

- This option offers 100 percent unlimited wellness benefits based on national age and gender guidelines
- You must satisfy a separate in-network and out-of-network deductible and out-of-pocket maximum
- You pay co-insurance after meeting the entire family deductible for all medical expenses and prescriptions

Health Savings Account (HSA)

An HSA is like a personal savings account with investment options for health care, except it's all tax-free. You may be eligible to participate in an HSA that is offered through the State of Georgia Flexible Benefits Program or by your employer. Participation through payroll deductions allows your contributions to be pre-tax. If your employer does not offer an HSA, you may still open an HSA with an independent HSA administrator/custodian. You may locate HSA Administrators at www.healthsavingsinfo.com/finding.htm.

You may open an HSA if you enroll in the SHBP HDHP and do not have other coverage through: 1) Your spouse's employer's plan 2) Medicare 3) Medicaid 4) General Purpose Health Care Spending Account (GPHCSA) or any other non-qualified medical plan.

- You can make contributions to a State of Georgia HSA only when enrolled in the SHBP HDHP
- You can contribute up to $3,000 single, $5,950 family as long as you are enrolled in the HDHP. These limits are set by federal law. Unused money in your account carries forward to the next Plan Year and earns interest
- HSA dollars can be used for eligible health care expenses even if you are no longer enrolled in the HDHP or any SHBP coverage
- HSA dollars can be used to pay for health care expenses (medical, dental, vision, over-the-counter medications) that the IRS considers tax-deductible that are **NOT** covered by any health plan (see IRS Publication 502 at www.irs.gov)

- HSA accounts cannot be combined with a General Purpose Healthcare Spending Account (GPHCSA), but can be combined with a limited purpose healthcare spending account (LPHCSA). Contact the State Personnel Administration or your employer
- You can contribute additional dollars if you are 55 or older (see IRS Publication 502 at www.irs.gov)

HRA and HSA participation impacts your eligibility and amount of dollars you can contribute to a Healthcare Spending Account. Additional information to assist you with understanding the rules and differences can be found on page 24 of this *Decision Guide*.

Preferred Provider Organization (PPO)

A Preferred Provider Organization (PPO) allows you to receive benefits from in-network and out-of-network providers, and provides access on a statewide and national basis across the United States. To receive the highest level of benefit coverage and to avoid filing claims and balance billing, you should use an in-network provider. If you use an out-of-network provider, the reimbursement will be lower and you will be subject to balance billing. No election of a primary care physician or referral to a specialist is required. This option requires that you satisfy a deductible with coinsurance and has an out-of-pocket maximum (OOP). When you meet the maximum, the PPO pays your covered services at 100 percent of the allowed amount. You will continue to pay your co-pays, however.

Considerations:

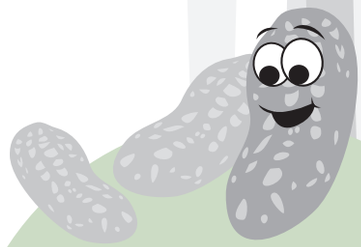
- Out-of-network benefits are paid at 60 percent with balance billing (the amount above the negotiated rate approved by the vendor)
- Co-payments do not apply toward deductibles or out-of-pocket maximum unless otherwise noted
- You must satisfy a separate in-network and out-of-network deductible and separate out-of-pocket maximum

Health Maintenance Organization (HMO)

A Health Maintenance Organization (HMO) allows you to receive benefits from participating providers only and does not require you to select a Primary Care Physician (PCP). HMOs provide 100 percent benefit coverage for preventive health care needs after paying applicable co-payments. Certain services are subject to a deductible and co-insurance. *See page 16 for more information.*

Considerations:

- Verify provider participation before selecting an HMO Option
- Coverage is available only when using in-network providers (except in cases of emergencies)
- Co-payments do not count toward your deductible or out-of-pocket maximum
- Both CIGNA Healthcare and UnitedHealthcare HMO options provide a national network and services are paid at 90% when received by a participating provider outside the State of Georgia
- Maintenance medications require only two co-pays for a 90 day supply when received at a retail pharmacy



shbp tip:

While not required, we strongly encourage you to select a PCP to assist in the overall coordination of care.

SHBP Eligibility

The SHBP covers dependents who meet SHBP guidelines and requires eligibility documentation before SHBP can send dependents' notification of coverage to the health plans.

Eligible dependents are:

- **Your legally married spouse,** as defined by Georgia Law
- **Your never-married dependent children who are:**

1. **Natural or legally adopted children under age 19**, unless they are eligible for coverage as employees. Children that are legally adopted through the judicial courts become eligible only after they are placed in your physical custody
2. **Stepchildren under age 19 who live with you** at least 180 days per year and for whom you can provide documentation satisfactory to the Plan that they are your dependents
3. **Other children under age 19** if they live with you permanently and legally depend on you for financial support – as long as you have a court order, judgment or other satisfactory proof from a court of competent jurisdiction
4. **Your natural children, legally adopted children or stepchildren** who are physically or mentally disabled prior to reaching age 26 and who depend on you for primary support
5. **Your natural children, legally adopted children, stepchildren or other children ages 19 through 25 from categories 1, 2, or 3 above** who are registered full-time students at accredited secondary schools, colleges, universities or nurse training institutions and, if employed, who are not eligible for a medical benefit plan from their employer. The number of credit hours required for full-time student status is defined by the school in which the child is enrolled

SHBP requires documentation annually from the college or university your student attends verifying he/she is a full-time student.

Making Changes When You Have a Qualifying Event

If you experience a qualifying event, you may be able to make changes for yourself and your dependents, **provided you request the change within 31 days of the qualifying event**. Also, your requested change must correspond to the qualifying event. For a complete description of qualifying events, see your SPD. You can contact the Eligibility Unit for assistance at 800-610-1863 or in the Atlanta area at 404-656-6322.

Qualifying events include, but are not limited to:

- Birth or adoption of a child or placement for adoption
- Change in residence by you, your spouse or dependents that results in ineligibility for coverage in your selected option because of location
- Death of a spouse or child, if the only dependent enrolled
- Your spouse's or dependent's loss of eligibility for other group health coverage
- Marriage or divorce
- Medicare eligibility

Please submit your request, within 31 days of the event to your personnel/ benefit coordinator. Requests should not be held waiting on additional information, such as Social Security Number, marriage or birth certificate.

Documentation Confirming Eligibility for Your Spouse or Dependents

SHBP requires documentation concerning eligibility of dependents covered under the plan.

- **Spouse:** A copy of your certified marriage certificate or a copy of your most recent Federal Tax Return (filed jointly with spouse) including legible signatures for you and your spouse with financial information blacked out
- **Natural or student child:** A copy of the certified birth certificate listing the parents by name or a letter of confirmation of birth for newborns. Birth cards without the parents' names are not acceptable
- For students age 19 through age 25, SHBP requires the child's birth certificate and documentation from the school's registrar's office verifying full-time student status and a completed and signed student status form
- **Stepchild:**

  1. A copy of the certified birth certificate showing your spouse is the natural parent;
  2. A copy of the certified marriage certificate showing the natural parent is your spouse; and
  3. A notarized statement that the dependent lives in your home at least 180 days per year

NOTE: No health claims will be paid until the documentation is received and approved by SHBP.

The member's Social Security Number MUST be written on each document so we can match your dependents to your record. Do not send originals as originals will not be returned.

health tip:

If your child is turning 19 and is a full-time student or disabled, you may be able to continue his/her coverage, provided you submit the proper documentation.

Benefits Comparison

Schedule of Benefits for You and Your Dependents for January 1, 2009 – December 31, 2009

	PPO OPTION		HRA OPTION	
	In-network CIGNA Healthcare, UnitedHealthcare	Out-of-network CIGNA Healthcare, UnitedHealthcare	In-network CIGNA Healthcare, UnitedHealthcare	Out-of-network CIGNA Healthcare, UnitedHealthcare
Covered Services	*The Plan Pays:*		*The Plan Pays:*	
Maximum Lifetime Benefit (combined for all SHBP Options)	$2 million		$2 million	
Pre-Existing Conditions (First year in Plan only, subject to HIPAA)	$1,000		None	
Lifetime Benefit Limit for Treatment of: (combined for PPO Option and HDHP) • Temporomandibular joint dysfunction (TMJ)	$1,100		$1,100	
Deductibles/Co-Payments: EE = Employee ES = Employee + Spouse EC = Employee + Child(ren) EF = Employee + Spouse + Child(ren)	$500 $1,000 $1,000 $1,500	$1,000 $2,000 $2,000 $3,000	$1,000* $1,750* $1,750* $2,500* **HRA credits will reduce this amount.*	
•Hospital deductible per admission for Medical & Behavioral Health	$250		Not applicable	
Out-of-Pocket Maximum: EE = Employee ES = Employee + Spouse EC = Employee + Child(ren) EF = Employee + Spouse + Child(ren)	$1,500 $2,250 $2,250 $3,000	$3,000 $4,500 $4,500 $6,000	$2,000* $3,250* $3,250* $4,500* *HRA credits will reduce this amount.*	
HRA Credits: EE = Employee ES = Employee + Spouse EC = Employee + Child(ren) EF = Employee + Spouse + Child(ren)	None		$500 $1,000 $1,000 $1,500	
Physicians' Services				
Primary Care Physician or Specialist Office or Clinic Visits: Treatment of illness or injury	$30 per office visit co-payment; subject to deductible for associated lab and x-ray	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Primary Care Physician or Specialist Office or Clinic Visits for the Following: • Wellness care/preventive health care • Annual gynecological exams (these services are not subject to the deductible)	$30 co-payment per office visit. No co-payment for associated tests and immunizations. Maximum of $1000 per person per Plan Year.	Not covered. Charges do not apply to deductible or annual out-of-pocket limits.	100% coverage; not subject to deductible	Not covered. Charges do not apply to deductible or annual out-of-pocket limits.

Dollar amounts, visit limitations, deductibles and out-of-pocket limits are based on a January 1 – December 31, 2009 Plan Year. NOTE: Coverage is defined as allowed eligible expenses. Exclusions and limitations vary among Plan options. Contact your specific Plan option for more information.

HIGH DEDUCTIBLE OPTION (HDHP)		HMO OPTIONS	
In-network CIGNA Healthcare, UnitedHealthcare	Out-of-network CIGNA Healthcare, UnitedHealthcare	CIGNA Healthcare, UnitedHealthcare	
The Plan Pays:		*The Plan Pays:*	*HMO Plan Differences:*
$2 million		$2 million	
None		None	
$1,100		No separate lifetime benefit limit	
$1,150 $2,300 $2,300 $2,300	$2,300 $4,600 $4,600 $4,600	$400 $600 $600 $800	
Not applicable		Not applicable	
$1,700 $2,900 $2,900 $2,900	$3,800 $7,000 $7,000 $7,000	$1,500 $2,250 $2,250 $3,000	
None		None	
90% coverage; subject to deductible	60% coverage; subject to deductible	$30 per office visit co-payment	
100% coverage; not subject to deductible	Not covered. Charges do not apply to deductible or annual out-of-pocket limits.	100% after a per visit co-payment of $30 for primary care and specialty care. No co-payment for immunizations and mammograms.	

Chart continued pg. 18

	PPO OPTION		HRA OPTION	
	In-network CIGNA Healthcare, UnitedHealthcare	Out-of-network CIGNA Healthcare, UnitedHealthcare	In-network CIGNA Healthcare, UnitedHealthcare	Out-of-network CIGNA Healthcare, UnitedHealthcare
Physicians' Services	*The Plan Pays:*		*The Plan Pays:*	
Maternity Care (prenatal, delivery and postpartum)	90% coverage; not subject to deductible after initial $30 co-payment	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Physician Services Furnished in a Hospital • Visits; surgery in general, including charges by surgeon, anesthesiologist, pathologist and radiologist	90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Physician Services for Emergency Care Non-emergency use of the emergency room not covered	90% coverage; subject to in-network deductible		90% coverage; subject to in-network deductible	
Outpatient Surgery— • When billed as office visit	90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
• When billed as outpatient surgery at a facility	90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Allergy Shots and Serum	100% for shots and serum; $30 per visit co-payment not subject to deductible (no co-payment if office visit not billed)	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Hospital Services				
Inpatient Services • Inpatient care, delivery and inpatient short-term acute rehabilitation services	90% coverage after deductible; and subject to a $250 per admission deductible	60% coverage after deductible; and subject to a $250 per admission deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
• Well-newborn care	100% coverage; not subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Surgery— Hospital/facility	90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Emergency Care—Hospital • Treatment of an emergency medical condition or injury • Non-emergency use of the emergency room not covered	90% coverage after $100 per visit co-payment; co-payment waived if admitted; subject to in-network deductible		90% coverage; subject to deductible	

HIGH DEDUCTIBLE OPTION (HDHP)		HMO OPTIONS	
In-network CIGNA Healthcare, UnitedHealthcare	Out-of-network CIGNA Healthcare, UnitedHealthcare	CIGNA Healthcare, UnitedHealthcare	
The Plan Pays:		*The Plan Pays:*	*HMO Plan Differences:*
90% coverage; subject to deductible	60% coverage; subject to deductible	100% after initial $30 co-payment	
90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	
90% coverage; subject to deductible		100% ($100 co-pay applies to facility expenses)	
90% coverage; subject to deductible	60% coverage; subject to deductible	100% after $30 co-payment if billed as office visit	
90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	
90% coverage; subject to deductible	60% coverage; subject to deductible	100% for shots and serum after a $30 per visit co-payment. No co-pay if office visit not billed.	
90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	
90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage not subject to deductible	
90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	
90% coverage; subject to in-network deductible		100% after a $100 per visit co-payment; if admitted co-payment waived; subject to deductible	

Chart continued pg. 20

	PPO OPTION		HRA OPTION	
	In-network CIGNA Healthcare, UnitedHealthcare	Out-of-network CIGNA Healthcare, UnitedHealthcare	In-network CIGNA Healthcare, UnitedHealthcare	Out-of-network CIGNA Healthcare, UnitedHealthcare
Outpatient Testing, Lab, etc.	*The Plan Pays:*		*The Plan Pays:*	
Laboratory; X-Rays; Diagnostic Tests; Injections— including medications covered under medical benefits—for the treatment of an illness or injury	90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Behavioral Health				
Mental Health and Substance Abuse Inpatient Facility and Partial Day Hospitalization NOTE: All services require prior authorization.	90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Mental Health and Substance Abuse Outpatient Visits and Intensive Outpatient NOTE: All services require prior authorization	90% coverage; subject to deductible $30 co-payment for office visit	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Dental				
Dental and Oral Care NOTE: Coverage for most procedures for the prompt repair of sound natural teeth or tissue for the correction of damage caused by traumatic injury. NOTE: Notification required	90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Temporomandibular Joint Syndrome (TMJ) NOTE: Coverage for diagnostic testing and non-surgical treatment up to $1,100 per person lifetime maximum benefit. This limit does not apply to the HMO.	90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Vision				
Routine Eye Exam NOTE: Limited to one eye exam every 24 months	90% coverage; not subject to deductible	Eye exam not covered	100% coverage; not subject to deductible	Eye exam not covered
Other Coverage				
Ambulance Services for Emergency Care NOTE: "Land or air ambulance" to nearest facility to treat the condition.	90% coverage; subject to in-network deductible		90% coverage; subject to in-network deductible	
Urgent Care Services	90% coverage after a $45 per visit co-payment; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible

HIGH DEDUCTIBLE OPTION (HDHP)		HMO OPTIONS	
In-network CIGNA Healthcare, UnitedHealthcare	Out-of-network CIGNA Healthcare, UnitedHealthcare	CIGNA Healthcare, UnitedHealthcare	
The Plan Pays:		*The Plan Pays:*	*HMO Plan Differences:*
90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible; office or independent lab/ x-ray 100% coverage	
90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; not subject to deductible for the UHC. CIGNA 90% coverage subject to deductible	
90% coverage; subject to deductible	60% coverage; subject to deductible	100% after $30 per visit co-payment. $10 co-payment for group therapy	
90% coverage; subject to deductible	60% coverage; subject to deductible	100% after $30 per visit co-payment; if inpatient/ outpatient facility, 90% subject to deductible	
90% coverage; subject to deductible	60% coverage; subject to deductible	100% after $30 co-payment for related surgery and diagnostic services; excludes appliances and orthodontic treatment; if inpatient/ outpatient facility, 90% subject to deductible	
90% coverage; not subject to deductible	Eye exam not covered	100% after $30 co-payment; not subject to deductible. $200 annual benefit for glasses and contacts	
90% coverage; subject to in-network deductible		100% coverage; not subject to deductible	
90% overage; subject to deductible	60% coverage; subject to deductible	100% after $35 co-payment; not subject to deductible	

Chart continued pg. 22

	PPO OPTION		HRA OPTION	
	In-network CIGNA Healthcare, UnitedHealthcare	Out-of-network CIGNA Healthcare, UnitedHealthcare	In-network CIGNA Healthcare, UnitedHealthcare	Out-of-network CIGNA Healthcare, UnitedHealthcare
Other Coverage	*The Plan Pays:*		*The Plan Pays:*	
Home Health Care Services NOTE: Prior approval required	90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Skilled Nursing Facility Services NOTE: Prior approval required	90% coverage after deductible; up to 120 days per Plan Year; subject to a $250 per admission deductible	Not covered	90% coverage; up to 120 days per Plan Year; subject to deductible	Not covered
Hospice Care NOTE: Prior approval required	100% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Durable Medical Equipment (DME)—Rental or purchase NOTE: Prior approval required for certain DME	90% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Acute Short-Term Rehabilitation Services • **Physical Therapy** • **Speech Therapy** • **Occupational Therapy** • **Other short term rehabilitative services**	90% coverage; subject to deductible; $20 per visit co-payment up to 40 visits per Plan Year (not to exceed a total of 40 visits combined, including any out-of-network visits)	60% coverage; subject to deductible; up to 40 visits per Plan Year (not to exceed a total of 40 visits, including any in-network visits)	90% coverage; subject to deductible; up to 40 visits per Plan Year (not to exceed a total of 40 visits combined, including any out-of-network visits)	60% coverage; subject to deductible; up to 40 visits per Plan Year (not to exceed a total of 40 visits combined, including any in-network visits)
Chiropractic Care NOTE: Coverage for up to a maximum of 20 visits per Plan Year.	90% coverage; after a $30 per visit co-payment; not subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Transplant Services NOTE: Prior approval required.	90% coverage at contracted transplant facility; subject to deductible and $250 per admission deductible	Not covered	90% coverage; subject to deductible	60% coverage; subject to deductible
Pharmacy				
Tier 1 Co-payment NOTE: No Tiers in HRA Option	$10	$10*	90% coverage; subject to deductible	60% coverage; subject to deductible
Tier 2 Co-payment	$30	$30*	NA	NA
Tier 3 Co-payment	$100	$100*	NA	NA

*Member must pay full charges at point of sale and submit a paper claim. Members will be reimbursed at the pharmacy network rate less the required co-payment for covered drugs. Member is responsible for charges that exceed the pharmacy network rate.

HIGH DEDUCTIBLE OPTION (HDHP)		HMO OPTIONS	
In-network CIGNA Healthcare, UnitedHealthcare	Out-of-network CIGNA Healthcare, UnitedHealthcare	CIGNA Healthcare, UnitedHealthcare	
The Plan Pays:		*The Plan Pays:*	*HMO Plan Differences*
90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; up to 120 visits per Plan Year	
90% coverage up to 120 days per Plan Year; subject to deductible	Not covered	90% coverage; up to 120 days per Plan Year; subject to deductible	
90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; subject to deductible	
90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage when medically necessary	
90% coverage up to 40 visits per therapy per Plan Year; subject to deductible (not to exceed a total of 40 visits combined, including any out-of-network visits)	60% coverage up to 40 visits per therapy per Plan Year; subject to deductible (not to exceed a total of 40 visits combined, including any in-network visits)	100% coverage after $25 per visit co-payment; up to 40 visits per therapy per Plan Year	
90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage after $30 co-payment per visit	
90% coverage at contracted transplant facility; subject to deductible	Not covered	90% coverage; subject to deductible	
80% coverage; subject to deductible $10 min./$100 max.	Not covered	$10	
80% coverage; subject to deductible $10 min./$100 max.	Not covered	$30	
80% coverage; subject to deductible $10 min./$100 max.	Not covered	$75	

HRA, HSA and Flexible Spending (FSA) Account Considerations

	HRA	HSA
Overview	A tax-exempt account that reimburses employees and dependents for qualified medical expenses. Can be funded by employer only. --- Available to SHBP members enrolled in an HRA. See benefits chart for amounts funded by SHBP.	A tax-exempt custodial account that exclusively pays for qualified medical expenses of the employee and his or her dependents. Can be funded by employee, employer, or other party. --- Available to SHBP members who elect HDHP. An HSA is available under the Flexible Benefits Program, your employer or you may participate as an individual. SHBP does not fund these accounts.
Can I have other coverage and take advantage of this benefit?	Yes.	No other general medical insurance coverage permitted. You cannot be enrolled in Medicare Parts A or Part B.
Can I participate in a Healthcare Spending Account?	You may enroll in a General Purpose FSA. You may use a Flexible Spending Account (FSA) for uncovered or unreimbursed portions of qualified medical costs.	You may enroll in a Limited Purpose FSA if you are enrolled in a Healthcare Spending Account (LPHCSA).
Who owns the money in these accounts?	SHBP. Money reverts back to SHBP upon loss of SHBP HRA coverage.	The employee.
Can these dollars be rolled over each year?	Yes.	Yes.
Is there a monthly service charge?	No.	Yes, $3.00 per account per month with the SPA Flexible Benefits Program. For other HSA accounts check with your HSA administrator.
What is the order in using these accounts?	HRA must be used before using the HCSA.*	Can only use Limited Purpose HCSA with the HSA, but it doesn't matter which is used first.
Can I take it with me?	Unused amounts can be distributed until depleted to pay for claims incurred before termination.	Fund disbursement is not tied to individual's employment. Unused amounts can be distributed tax-free for qualified medical expenses. Subject to income and excise tax for non-qualified expenses.

*When determining how much money to set aside in an FSA, employees should consider the first $500 (employee) or $1,000 {employee + spouse OR employee + child(ren) OR $1,500 (employee + spouse + child(ren)} of qualified medical expenses will be covered by the HRA.

If You Are Retiring… What You Need to Know

State Health Benefit Plan (SHBP) Medicare Policy

If you want to have health insurance under SHBP when you retire, you must enroll for coverage for you and any eligible dependents during the OE period prior to your retirement.

Once retired, you will have an annual Retiree Option Change Period that allows you to change your Plan option only. You may add dependents only if you experience a qualifying event and request the change within 31 days and provide the documentation required by SHBP.

The following information and "Important Notices about Your Prescription Drug Coverage and Medicare" are provided to assist you with Retirement Planning. ***See page 27.***

Federal Law requires SHBP to pay primary benefits for active employees and their dependents. Active members or their covered dependents may choose to delay Medicare enrollment. Termination of active employment is a qualifying event for enrolling in Medicare without penalty. *Except HDHP, see page 29.*

1. SHBP calculates premiums and claims payments based upon Medicare enrollment for retirees 65 or older or those eligible for Medicare due to disability. SHBP will coordinate benefits for members who are enrolled for Medicare Parts, A, B and/or D. Premiums will be reduced for each part of Medicare for which the retiree enrolls after you notify SHBP of your Medicare enrollment. SHBP is unable to refund premiums when notification is not received timely.

2. SHBP will pay primary benefits for non-enrolled Medicare eligible retirees as well as retirees who are not entitled to Medicare because they did not participate in Social Security or pay Medicare taxes. The premiums for these primary payments will be increased the month in which the retiree (or dependent spouse) reaches 65 or becomes eligible for Medicare due to disability.

Members who are enrolled in Medicare due to End Stage Renal Disease (ESRD) will need to contact the Social Security Administration to determine when Medicare becomes primary.

Retirees have the same options as active employees as well as the two Medicare Advantage Private Fee for Service Plans (MA PFFS). The MA PFFS Plans have been designed to reduce the out-of-pocket expenses for retirees who are 65 or older with Medicare Parts A and B.

If you enroll in one of the MA PFFS options once retired, you do not need to join an individual Medicare Part D plan as these options includes Part D and coordinate benefits with all parts of Medicare.

If you elect to enroll in another Medicare Part D plan, your coverage in the MA-PFFS option will end. To enroll in a SHBP sponsored MA PFFS, you must make your election on the Personalized Change Form and submit to SHBP. The MA PFFS option will mail you an application that you will need to complete.

You are not required to enroll in one of the MA PFFS options; however, to pay the lowest premiums with SHBP and receive richer benefits, you may want to consider enrolling in Medicare Parts A, B and D.

If you are enrolled in Medicare Parts A or Part B, you are eligible for Part D. SHBP will provide secondary coverage to Medicare prescription drug plans. In many cases, a basic Part D plan will meet your needs as SHBP will pay benefits during any deductible and the "donut hole" that may apply under your Part D option.

Your individual pharmacy needs will determine the level of coverage that is best for you.

More detailed information can be found in the Retiree Decision Guide or at www.dch.georgia.gov/shbp_plans.

Georgia Department of
Community Health

Two Peachtree Street
Atlanta, GA 30303
(404) 656-6322 • (800) 610-1863

October 1, 2008

About Your Prescription Drug Coverage with PPO, United Healthcare HMO, UnitedHealthcare Definity, Kaiser Permanente, CIGNA Healthcare Open Access Plus PPO, CIGNA Healthcare Open Access Plus In-Network HMO, CIGNA Healthcare Choice Fund HRA and Medicare

For Plan Year: January 1–December 31, 2009

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the State Health Benefit Plan (SHBP) and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The State Health Benefit Plan has determined that the prescription drug coverage offered by the UnitedHealthcare PPO, United Healthcare HMO, UnitedHealthcare Definity, Kaiser Permanente, CIGNA Healthcare Open Access Plus PPO, CIGNA Healthcare Open Access Plus In-Network HMO, CIGNA Healthcare Choice Fund HRA offered under SHBP is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a sixty (60) day Special Enrollment Period (SEP) because you lost creditable coverage to join a Part D plan.

In addition, if you lose SHBP coverage voluntarily, you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period. You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

If you decide to join a Medicare drug plan, your State Health Benefit Plan coverage will be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan. You can keep your SHBP coverage if you elect Part D and SHBP will coordinate with Part D coverage. Your premiums will also be reduced by each Part of Medicare you have. You should send a copy of your Medicare cards to SHBP at P. O. Box 38342, Atlanta, GA 30334.

If you do decide to join a Medicare drug plan and drop your coverage with the State Health Benefit Plan, be aware that you and your dependents can not get this coverage back if you are a retiree.

You should also know that if you drop or lose your coverage with SHBP and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium may go up by at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information about this Notice or Your SHBP Current Prescription Drug Coverage…

Contact the SHBP Eligibility Unit at (404) 656-6322 or (800) 610-1863. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the State Health Benefit Plan changes. You also may request a cop

For More Information about Your Options under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the *Medicare* & *You* handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the *Medicare* & *You* handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

Date: October 1, 2008

Name of Sender: State Health Benefit Plan

Office: Call Center

Address: P. O. Box 38342, Atlanta, GA 30334

Phone Number: (404) 656-6322 or (800) 610-1863

Georgia Department of
Community Health

Two Peachtree Street
Atlanta, GA 30303
(404) 656-6322 • (800) 610-1863

October 1, 2008

Important Notice from the SHBP about Your Prescription Drug Coverage and Medicare

About Your Prescription Drug Coverage with the CIGNA Healthcare Open Access Plus and UnitedHealthcare High Deductible Health Plan and Medicare

For Plan Year: January 1–December 31, 2009

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the State Health Benefit Plan (SHBP) and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The SHBP has determined that the prescription drug coverage under the High Deductible Health Plan (HDHP) Option, is on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Non-Creditable Coverage. **This is important, because most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage through the HDHP offered by SHBP.**

3. You have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join. Read this notice carefully as it explains your options.

Consider joining a Medicare drug plan. You can keep your HDHP coverage offered by the SHBP. You can keep the coverage regardless of whether it is good as the Medicare drug plan. However, because your existing coverage is, on average, NOT at least as good as standard Medicare prescription drug coverage, you may pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage. However, if you lose your HDHP coverage under SHBP; you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period.

You Need to Make a Decision

When you make your decision, you should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you decide to join a Medicare drug plan, your HDHP coverage under SHBP will be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

If you enroll in Medicare Part D when you become eligible for Medicare Part D, you can keep your HDHP coverage even if you elect Part D and the HDHP will coordinate benefits with the Part D coverage.

If you do decide to join a Medicare drug plan and drop your HDHP coverage under SHBP, be aware that you and your dependents will not be able to get your SHBP coverage back if you are a retiree.

You should also know that if you drop or lose your HDHP coverage with SHBP and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium may go up by at least 1 percent of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19 percent higher than the base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information about this Notice or Your Current Prescription Drug Coverage…

Contact the SHBP Call Center at (404) 656-6322 or (800) 610-1863 for further information. NOTE: You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if your SHBP coverage changes. You also may request a copy.

For More Information about Your Options under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the *"Medicare & You"* handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date: October 1, 2008
Name of Sender: State Health Benefit Plan
Office: Call Center
Address: P. O. Box 38342, Atlanta, GA 30334
Phone Number: (404) 656-6322 or (800) 610-1863

Notes

Notes

Notify the Plan of any fraudulent activity regarding Plan members, providers, payment of benefits, etc. Call 1 877-878-3360 or 404 463-7590.

Penalties for Misrepresentation

If an SHBP participant misrepresents eligibility information when applying for coverage, during change of coverage or when filing for benefits, the SHBP may take adverse action against the participants, including but not limited to terminating coverage (for the participant and his or her dependent[s]) or imposing liability to the SHBP for fraud or indemnification (requiring payment for benefits to which the participant or his or her beneficiaries were not entitled). Penalties may include a lawsuit, which may result in payment of charges to the Plan or criminal prosecution in a court of law.

In order to avoid enforcement of the penalties, the participant must notify the SHBP immediately if a dependent is no longer eligible for coverage or if the participant has questions or reservations about the eligibility of a dependent. This policy may be enforced to the fullest extent of the law.

GEORGIA'S NUTS ABOUT HEALTH!

Thanks to all of you who participated in the State Health Benefit Plan's "Georgia's Nuts About Health" wellness initiative. It's never too late to be healthy!
www.nutsabouthealth.ga.gov

Georgia Department of Community Health